

South Carolina Department of Disabilities & Special Needs

Contract Compliance Review Tool

Day and Residential Service Providers & In-home Supports and Rehabilitation Supports Providers

ADMINISTRATIVE INDICATORS & GUIDANCE

Review Year July 2018 through June 2019

Shaded indicators represent data collected for Waiver Evidentiary Reports or Home and Community Based Services Transition Plan Reporting.

A1 Administrative / Operational Issues		Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.
<i>A1 indicators are scored met/ not met.</i>		
A1-01	For those for whom outlier status has been approved due to the need for enhanced staff support, the Board / Provider provides the additional support as outlined in the approved request.	250-11-DD requires that residential service providers must retain staff schedules that document the increased level of supervision is being provided. The QIO will verify the presence of additional staffing support as well as other supports (i.e., Behavior Support Plan and training [Habilitation] strategies) that are needed in order to decrease the need for outlier funding. Source: MOA DDSN/HHS, 250-11-DD
A1-02	For those for whom outlier status has been approved due to the need for 1:1 staff support, the Board / Provider provides the additional support as outlined in the approved request.	At the end of each shift that 1:1 Supervision was provided the direct care staff assigned to provide the 1:1 supervision must document that the 1:1 supervision was provided. The QIO will verify the presence of additional staffing support as well as other supports (i.e., Behavior Support Plan and training [Habilitation] strategies) that are needed in order to decrease the need for outlier funding. Source: MOA DDSN/DHHS, 250-11-DD
A1-03	The Board / Provider has a Human Rights Committee that is composed of a minimum of 5 members and includes representation from a family member of a person receiving services, a person representing those receiving services or a self-advocate nominated by the local self-advocacy group, and a representative of the community with expertise or a demonstrated interest in the care and treatment of persons (employees or former employees must not be appointed). The Board/ Provider has a Human Rights Committee member list (which identifies the above), along with an attendance log for each Human Rights Committee meeting.	South Carolina Code Ann. 44-26-70 requires that each DDSN Regional Center and DSN Board establish a Human Rights Committee. Contract service providers may either use the Human Rights Committee of the local DSN Board or establish their own Committee. Contract providers must have formal documentation of this relationship. Source: South Carolina Code Ann. 44-26-70 and 535-02-DD
A1-04	The Human Rights Committee will provide review of Board / Provider practices to assure that consumer's due process rights are protected.	Minutes shall be taken of each meeting and shall reflect the date and time of the meeting, those Committee members present and absent, and a record of decisions and recommendations in a manner that readily identifies the issues reviewed, the decisions reached, and the follow-up that is necessary. In addition to reviewing Behavior

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		<p>Support Plans and Psychotropic Medications, the provider must document the HRC's review of any use of emergency restraints. The HRC must also receive notification of alleged abuse, neglect, or exploitation. Each Human Rights Committee, in coordination with the Agency, may establish its own mechanism to receive such reports. The HRC should also advise the DSN Board or contract provider agency on other matters pertaining to the rights of people receiving services and other issues identified by the Human Rights Committee or Agency. The sharing of this information and related discussion must be documented in the HRC meeting minutes.</p> <p>Source: 535-02-DD</p>
A1-05	Board / Provider implements a risk management and quality assurance program consistent with 100-26-DD and 100-28-DD.	<p>Board / Provider demonstrates implementation of risk management/quality assurance principles and signed, dated minutes from the Risk Management Committee quarterly reviews through the following measures:</p> <ul style="list-style-type: none"> • designated risk manager and a risk management committee • written policies/procedures used to collect, analyze and act on risk data • documentation of remediation taken; • correlating risk management activities with quality assurance activities; • developing contingency plans to continue services in the event of an emergency or the inability of a service provider to deliver services. • For residential and day service providers: Review of medication errors and remediation (if not conducted through a separate committee for this purpose, documentation must be available). • For residential and day service providers: Review of any restraints or restrictive procedures used to ensure compliance with applicable directives. • Review of any GERD/ Dysphagia Consultation reports to ensure there has been follow-up on recommendations. <p>Source: 100-26-DD and 100-28-DD</p>
A1-06	<p>Board / Provider demonstrates usage of the current incident management profile data report to:</p> <ul style="list-style-type: none"> • evaluate provider specific trends over time • evaluate/explain why the provider specific rate is over, under or at the statewide average • demonstrate systemic actions to prevent future incidents/ allegations. 	<p>Provider must utilize data available within the DDSN Incident Management System and Therap GER provider reports for the prior 12 month period. In the event the provider has not had any reports of incidents, they must document the review of trend data and discuss continued actions to prevent incidents and respond where appropriate.</p>
A1-07	The Board / Provider follows SCDDSN procedures regarding Medication Error/ Event Reporting, as outlined in 100-29-DD.	<p>For DDSN Residential and Day Services Providers:</p> <p>Determine if the Board / Provider has developed an internal database to record, track, analyze, and trend medication errors or events associated with the administration of medication errors. The method for calculating medication error rate has been defined in</p>

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		DDSN Directive 100-29-DD. Source: 100-29-DD
A1-08	The Board/ Provider utilizes an approved curriculum or system for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations.	*Not Applicable to Case Management Providers Source: 567-04-DD
A1- 09	Upper level management staff of the Board/Provider conduct quarterly unannounced visits to all residential settings to assure sufficient staffing and supervision are provided. Documentation of the visit must include the date and time of the visit, the names of the staff/caregivers and consumers present, notation of any concerns and actions taken in response to noted concerns.	When a residential setting does not utilize a shift model for staffing (e.g. CTH I and SLPI) visits need only to be conducted quarterly. The Provider shall conduct quarterly unannounced visits to all of its residential locations across all shifts excluding third shift in Community Training Home I and Supervised Living I Programs, including weekends, to assure sufficient staffing and supervision per the consumers' plans. Managers should not visit homes they supervise but should visit homes managed by their peers. Senior management may visit any/all of the homes. Documentation of the visit must include the date and time of the visit, the names of the staff/caregivers and consumers present, notation of any concerns and actions taken in response to noted concerns. SLP II should include visits to all apartments. Please note: It is not necessary to visit individual SLP II apartments, during 3 rd shift, although 3 rd shift checks to the complex/staff review are still required. CIRS and CTH I locations do not require unannounced 3 rd shift checks. *Quarterly = 4 times per year with no more than 4 months between visits. Source: Contract...Capitated Model Article III
A1- 10	The Board / Provider /Intake Provider keeps service recipients' records secure and information confidential.	Source: 167-06-DD
A1- 11	The Provider agency of HASCI Division Rehabilitation Supports (RS) maintains required administrative records for the RS Program.	Source: Rehabilitation Supports Manual
A1- 12	Board/Provider conducts all residential admissions/discharges in accordance with 502-01-DD.	Source: 502-01-DD
A1- 14	The Residential Habilitation provider must have procedures that specify the actions to be taken to assure that <u>within 24 hours</u> following a visit to a physician, Certified Nurse Practitioner (CNP), or Physician's Assistant (PA), all ordered treatments will be provided. The procedures must include the specific steps to be taken and by whom. The procedures must be current.	Source: Residential Habilitation Standards
A1- 15	The Board/ Provider follows procedures regarding Medication Technician Certification program, as outlined in 603-13-DD.	Source: 603-13-DD
A1- 17	The Provider demonstrates agency-wide usage of Therap for the maintenance of Residential Services records according to the implementation schedule approved by DDSN.	Source: DDSN Therap Requirements

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A1- 18	The Provider demonstrates agency-wide usage of Therap for the maintenance of Day Services records according to the implementation schedule approved by DDSN.	Source: DDSN Therap Requirements
A1-20	The Provider demonstrates agency-wide usage of Therap for General Event Reports (GERs) according to the implementation schedule approved by DDSN.	*Applies to Day and Residential Services only. Source: DDSN Therap Requirements
A2	Fiscal Issues <i>A2 indicators are scored met/ not met.</i>	<i>Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.</i>
A2-01	The Governing Board approves the annual budget and Comprehensive Financial Reports are presented at least quarterly to the Governing Board with a comparison to the approved budget.	Source: Contract for ...Capitated Model and Contract for Non-Capitated Model
A2-02	An Annual Audit Report is presented to Governing Board once a year and includes the written management letter. [Board Providers Only]	Source: 275-04-DD
A2-03	The person's financial responsibility is made known to them by the Board / Provider. [All Residential Providers]	Source: 200-12-DD
A3	Staff Qualifications, Training, and Reporting Requirements <i>A3 Indicators are scored based on the percentage of compliant files reviewed.</i>	<i>Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.</i>
A3-27 R	The Board /Provider employs Residential Staff who meet the minimum education requirements for the position.	Refer to SCDDSN Residential Habilitation Standards for educational and vocational requirements for all staff including those providing Intensive Behavioral Intervention (Residential Habilitation Standard 7.7).
A3-28 R	The Board /Provider employs Residential Staff who meet the criminal background check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-29 R	The Board /Provider employs Residential Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-30 R	The Board /Provider employs Residential Staff who meet the DSS Central Registry check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-31 R	The Board /Provider employs Residential Staff who meet the TB Testing requirements for the position.	Source: DDSN Directive 603-06-DD
A3-32	The Board /Provider employs Residential Staff with acceptable reference check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-33 R	The Board /Provider employs Day Services Staff who meet the minimum education requirements for the position.	Refer to SCDDSN Day Services Standards for educational and vocational requirements.
A3-34 R	The Board /Provider employs Day Services Staff who meet the criminal background check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-35 R	The Board /Provider employs Day Services Staff who meet the CMS "List of Excluded Individuals/ Entities" check requirements for the position.	Source: DDSN Directive 406-04-DD

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A3-36 R	The Board /Provider employs Day Services Staff who meet the DSS Central Registry check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-37 R	The Board /Provider employs Day Services Staff who meet the TB Testing requirements for the position.	Source: DDSN Directive 603-06-DD
A3-38	The Board / Provider employs Day Services Staff with acceptable reference check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-39 R	The Board / Provider employs/ contracts Respite/ In-Home Support staff who meet the minimum education requirements for the position.	Agencies that are contracted will be reviewed separately.
A3-40 R	The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the criminal background check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-41 R	The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the CMS “List of Excluded Individuals/ Entities” check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-42 R	The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the DSS Central Registry check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-43 R	The Board / Provider employs/ contracts Respite/ In-Home Support Staff who meet the TB Testing requirements for the position.	Source: DDSN Directive 603-06-DD
A3-44	The Board / Provider employs/ contracts Respite/ In-Home Support Staff with acceptable reference check requirements for the position.	Source: DDSN Directive 406-04-DD
A3-51	Residential staff receive ANE training as required.	Source: Residential Habilitation Standards and DDSN Directive 534-02-DD
A3-52	Residential staff receive training as required.	Source: Residential Habilitation Standards and DDSN Directive 567-01-DD
A3-53	Day Services staff receive ANE training as required.	Source: Day Services Standards and DDSN Directive 534-02-DD
A3-54	Day Services staff receive training as required.	Source: Day Services Standards and DDSN Directive 567-01-DD
A3-55	Respite/ In-Home Supports staff/ contractors receive ANE training as required.	Note: The indicator will be scored using the number of compliant files/ the total number of files reviewed for this indicator. Source: DDSN Directive 534-02-DD
A3-56	Respite/ In-Home Supports staff/ contractors receive training as required.	Refer to DDSN Directive 567-01-DD
A3-57	Annually, employees are made aware of the False Claims Recovery Act, that the Federal government can impose a penalty for false claims, that abuse of the Medicaid Program can be reported and that reporters are covered by Whistleblowers’ laws.	Source: Contract for ... Capitated Model and Source: Contract for ... Non-Capitated Model
A3-58	Board / Provider follows SCDDSN procedures for submitting initial reports for allegations of abuse / neglect / exploitation as outlined in 534-02-DD.	Source: DDSN Directive 534-02-DD
A3-59	Board / Provider follows SCDDSN procedures for submitting internal final reports for allegations of abuse / neglect / exploitation as outlined in 534-02-DD.	Source: DDSN Directive 534-02-DD

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A3-60	Board / Provider follows SCDDSN procedures for submitting initial critical incident reports as outlined in 100-09-DD.	Source: DDSN Directive 100-09-DD
A3-61	Board / Provider follows SCDDSN procedures for submitting internal final critical incident reports as outlined in 100-09-DD.	Source: DDSN Directive 100-09-DD
A3-62	Board / Provider follows SCDDSN procedures for submitting initial reports of death or impending death as outlined in 505-02-DD.	Source: DDSN Directive 505-02-DD
A3-63	Board / Provider follows SCDDSN procedures for submitting internal final reports of death or impending death as outlined in 505-02-DD.	Source: DDSN Directive 505-02-DD
A3-64	The "Swallowing Disorders Checklist" is completed annually.	Annual completion of the Swallowing Disorders Checklist is required for individuals receiving residential services. Staff can use the checklist for an individual receiving day services if there is an ongoing concern. The protocol must be completed for any choking incident that occurs while at the Day Program. Source: 535-13-DD
A3-65	If a critical incident due to choking (with airway obstruction) occurred or if a non-obstructing choking incident occurred, "yes" responses were noted on the "Swallowing Disorders Checklist" and the "Swallowing Disorders Follow-Up Assessment" was completed not more than five business days after the incident and submitted to DDSN for review.	Source: 535-13-DD
A3-66	If "yes" was noted as a response to any item (other than choking) on the "Swallowing Disorders Checklist", the "Swallowing Disorders Follow-Up Assessment" was completed and submitted with the "Checklist" to DDSN for review, not more than ten business days after responding "yes" to an item on the "Checklist".	Source: 535-13-DD
A3-67	All actions/recommendations included in "Required Provider Follow-Up" on the Swallowing Disorders Consultation Summary, were added to the person's plan (residential, day services or case management) and implemented within 30 calendar days or reason for non-implementation was documented.	The person's Plan (residential, day services or case management) should be amended to include any actions/recommendations noted in "Required Provider Follow-Up" resulting from the review of the "Checklist" and the "Assessment". All actions/recommendations noted in "Required Provider Follow-Up" must be implemented within 30 calendar days or there must be written justification for non-implementation. Source: 535-13-DD

SERVICE AREA INDICATORS & GUIDANCE

Review Year July 2018 through June 2019

HRS HASCI Division Rehabilitation Supports		<i>Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.</i>
HRS-01	The RS Record contains a valid Medical Necessity Statement (MNS).	Source Document: Rehabilitation Supports Manual
HRS-02	The RS Record documents a comprehensive assessment of needs and strengths to guide development or update of an IPOC.	Source Document: Rehabilitation Supports Manual
HRS-03	The RS Record contains a valid Individual Plan of Care (IPOC).	Source Document: Rehabilitation Supports Manual
HRS-04	The RS Record contains 90 Day Progress Reviews of the IPOC.	Source Document: Rehabilitation Supports Manual
HRS-05	The RS Record contains a Rehabilitation Supports Summary Note for each day that RS were received.	Source Document: Rehabilitation Supports Manual
HRS-06	The RS Record contains a Rehabilitation Supports Monthly Progress Summary for each month RS were received.	Source Document: Rehabilitation Supports Manual
HRS-07	The RS service provision billed to SCDDSN is substantiated in the RS Record.	Source Document: Rehabilitation Supports Manual
RS1 Residential/ Health Services		<i>Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.</i>
RS1-01 R	The Residential Support Plan must include: a) The type and frequency of care to be provided b) The type and frequency of supervision to be provided c) The functional skills training to be provided d) Any other supports/interventions to be provided e) Description of how each intervention will be documented.	Source: Residential Habilitation Standards
RS1-02 R	A comprehensive functional assessment: A. Is completed prior to the development of the initial plan B. Is updated as needed to insure accuracy.	The assessment does not have to be re-done annually. It is acceptable to review the assessment and indicate the date of review and the fact that the assessment remains current and valid. This notation must be signed or initialed by the staff that completed the review. Source: Residential Habilitation Standards
RS1-03 R	Within 30 days of admission and within every 365 days thereafter, a residential plan is developed: a) that supports the person to live the way he/she wants to live b) that reflects balance between self-determination and health and safety	Source: Residential Habilitation Standards

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	c) that reflects the interventions to be applied.	
RS1-04	The Plan must include: a) The goals of the person related to Residential Habilitation b) The functional skills training to be provided.	Source: Residential Habilitation Standards
RS1-05 R	The effectiveness of the residential plan is monitored and the plan is amended when: a) No progress is noted on an intervention b) new intervention, strategy, training, or support is identified; or c) The person is not satisfied with the intervention.	As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the strategy must be amended, and if necessary, the Plan as well. Source: Residential Habilitation Standards
RS1-06	A quarterly report of the status of the interventions in the plan must be completed.	Source: Residential Habilitation Standards
RS1-07	People are informed of their rights, supported to learn about their rights, and supported to exercise their rights.	All people residing in CTH I, CTH II, CRCF, CIRS, SLP I and SLP II must be informed of their rights and supported to learn about and exercise their rights unless there is documentation in the file that the person is fully capable of understanding their rights and there is an assessment that confirms this. Source: Residential Habilitation Standards
RS1-08	Personal freedoms are not restricted without due process.	Due process means human rights review of any restriction. The person must be offered the opportunity to attend the HRC meeting and have someone accompany them to assist in advocating for themselves, if they so desire. Verified by Service Notes. Source: Residential Habilitation Standards, 535-02-DD
RS1-09	People are expected to manage their own funds to the extent of their capability.	Source: Residential Habilitation Standards 200-12-DD Management of Funds for Individuals
RS1-10	People who receive services are trained on what constitutes abuse and how and to whom to report.	All people who reside in CTH I, CTH II, CRCF, CIRS, SLP II and SLP I require training in what constitutes abuse and how and whom to report it unless there is documentation in the file that they are capable of reporting and there is an assessment to confirm this. Source: Residential Habilitation Standards, 534-02-DD
RS1-11	Effective 1/1/2019 -A legally enforceable agreement (lease, residency agreement or other form of written agreement) is in place for each person.	This indicator will be measured beginning 1/1/2019. Source: Residential Habilitation Standards
RS1-12	People receive a health examination by a licensed Physician, Physician's Assistant, or Certified Nurse Practitioner who determines the need for and frequency of medical care and there is documentation that the recommendations are being followed.	Source: Residential Habilitation Standards
RS1-13	People receive a dental examination by a licensed Dentist who determines the need for and frequency of dental care, and there is documentation that the Dentist's recommendations are being carried out.	A person who is edentulous may be checked by a physician. Note: If a person has refused dental care, there must be documentation of this in the file. Source: Residential Habilitation Standards

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RS2	Residential/ Behavior Support Services	Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.
RS2-01	Behavior(s) that pose a risk to the person, others, the environment, or that interfere with his/her ability to function in the environment are addressed.	Source: 600-05-DD
RS2-02	<p>Prior to the development of a behavior support plan, indirect assessment including the following must be conducted:</p> <ol style="list-style-type: none"> Record review of DDSN Support Plan and, if they exist, existing behavior support plan and supervision plan. Interview using the Functional Assessment Interview Form (O'Neill, et al., 2014) <u>or</u> another empirically validated functional assessment instrument - such as the QABF (Questions About Behavioral Function, Matson & Vollmer, 1995) - with two or more people who spend the most time with the person (can include the person) must include (or be supplemented by additional assessment documentation which includes) the following: <ol style="list-style-type: none"> Description of problem behavior Listing of ecological and setting events that predict the occurrence and/or non-occurrence of the behavior Listing of possible antecedents that predict the occurrence and/or non-occurrence of the behavior Listing of possible consequences (access, escape/avoid, automatic) that maintain the problem behavior Record of information on the efficiency of the problem behavior List of functional alternatives the person currently demonstrates Description of the person's communication skills Description of what to do and what to avoid in teaching Listing of what the person likes (potential reinforcers) Listing of the history of the problem behavior(s), previous interventions, and effectiveness of those efforts Development of summary statements based on the <i>Functional Assessment Interview</i> (contains information on setting events, antecedents, problem behavior, and consequences) 	<p>Written information in the BSP and/or assessment file indicates that each component of the assessment was conducted.</p> <ol style="list-style-type: none"> Does the Support Plan reflect the need for behavior support services? A completed Functional Assessment Interview form or other empirically validated functional assessment instrument (and, if necessary, supplemental assessment documentation) containing the 10 items in section b must be available. <p>If the QABF (or other empirically validated functional assessment interview tool) is used there must be information provided in the assessment results (via a note) that specifies where information on each component is located.</p> <ol style="list-style-type: none"> These must be specified in the functional assessment document. <p>Source: Residential Habilitation Standards</p>
RS2-03	<p>Direct Assessment must be conducted to verify the indirect assessment information. It includes:</p> <p>Observational data collection forms and/or observational summaries that represent <u>two or more sessions</u> using A-B-C recording in direct observation for a minimum of:</p> <ol style="list-style-type: none"> <u>3 or more total hours or</u> <u>20 occurrences of the target behavior(s).</u> <p>If no problem behavior is observed, observational information must be summarized to</p>	<p>A summary must be included in the functional assessment (document) that includes the relative frequency of specific antecedents and consequences for individual problem behaviors. This can be either a table or narrative format.</p> <p>The functional assessment is a document that can be separate from the BSP (conclusions referenced in the BSP) in the BSP. In either case, the entire functional assessment document must be available.</p>

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	<p>describe contexts that support the non- occurrence of target behavior.</p> <p>If observational data do not verify the indirect assessment information, then the summary statements must be revised to correspond to the direct assessment data.</p>	<p>If during observations no target behaviors are observed, either summarized A-B-C data from staff observations or conduct additional observations that do include occurrences of the target behavior(s) must be included.</p> <p>Source: Residential Habilitation Standards</p>
RS2-04	<p>Behavior Support Plans must contain:</p> <ol style="list-style-type: none"> a) Description of the person: <ol style="list-style-type: none"> 1) Name, age, gender, residential setting, 2) Diagnoses (medical and psychiatric), 3) Intellectual and adaptive functioning, 4) Medications (medical and psychiatric), 5) Health concerns, 6) Mobility status, 7) Communication skills, 8) Daily living skills, 9) Typical activities and environments, 10) Supervision levels, 11) Preferred activities, items, and people, and 12) Non-preferred activities, items, and people. b) Locations where BSP will be implemented and identification of program implementers. c) Problem Behaviors and Replacement Behaviors in terms that are observable, measurable, and on which two independent observers can agree. d) Summary of direct assessment results. e) Objectives for each problem behavior, including: <ol style="list-style-type: none"> 1) Person's name, 2) Operational, measurable and observable way to describe behavior, 3) Conditions under which the behavior occurs or should occur, and 4) Criteria for completion (performance and time). f) Competing Behavior Model for each class of problem behavior that includes function of problem behavior and replacement behavior based on direct assessment g) Objectives for each replacement behavior, including: <ol style="list-style-type: none"> 1) Person's name, 2) Measurable and observable way to describe behavior, 3) Conditions under which the behavior occurs or should occur, and 4) Criteria for completion (performance and time). h) Support Procedures <ol style="list-style-type: none"> 1) Setting Event/Antecedent Strategies 	<ol style="list-style-type: none"> a) Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5. b) Procedures for training DSP(s) must be documented in either the BSP, training materials, or training documentation. c) Documentation of DSP training must be present to indicate training prior to the effective date / implementation date of any addendum/amendment to the BSP. Documentation must specify: 1) training on observation and behavioral data collection system and on treatment procedures, and 2) retraining on 1if needed. <i>Note: N/A with explanation may be acceptable</i> d) If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing. <i>Note: If N/A, then explanation is needed</i> <p>If the BSP addresses more than one setting (e.g., Day Program, Home, etc.), then the fidelity check should, on a rotating basis, be conducted in each setting addressed by the plan.</p>

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	<ul style="list-style-type: none"> 2) Teaching Strategies 3) Consequence Strategies 4) Crisis Management Strategies 5) Data Recording Method 6) Data Collection Forms 	Source: Residential Habilitation Standards
RS2-05	<p>Behavior Support Plan Implementation</p> <ul style="list-style-type: none"> a) DSP(s) responsible for implementing a BSP must be fully trained to: <ul style="list-style-type: none"> 1) collect behavioral data, and 2) implement the BSP procedures b) Procedures for training DSP(s) on implementation must include: <ul style="list-style-type: none"> 1) written and verbal instruction, 2) modeling, 3) rehearsal, and 4) trainer feedback. c) Documentation of DSP(s) training must accompany the plan and must include: <ul style="list-style-type: none"> 1) person's name, 2) date of initial training, 3) date of additional DSP(s) training, 4) names and signatures of DSP(s) trained, and 5) name of trainer and/or authorized secondary trainer. d) Fidelity procedures must occur quarterly and must document direct observation of DSP(s) implementing procedures according to the plan. Documentation must include: <ul style="list-style-type: none"> a) person's name, b) name(s) of DSP(s) being observed, c) date, location and time (including duration) of observation, d) description of procedures observed, e) directions and/or description for scoring DSP performance, f) signature of observed DSP, and g) signature of the observer. 	<ul style="list-style-type: none"> a) Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5. b) Procedures for training DSP(s) must be documented in either the BSP, training materials, or training documentation. c) Documentation of DSP training must be present to indicate training prior to the effective date / implementation date of any addendum/amendment to the BSP. Documentation must specify: 1) training on observation and behavioral data collection system and on treatment procedures, and 2) retraining on #1 if needed. d) <i>Note: N/A with explanation may be acceptable</i> e) If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing. f) <i>Note: If N/A, then explanation is needed</i> g) If the BSP addresses more than one setting (e.g., Day Program, Home, etc.), then the fidelity check should, on a rotating basis, be conducted in each setting addressed by the plan. <p>Source: Residential Habilitation Standards</p>
RS2-06	<p>Progress monitoring must occur at least monthly and rely on progress summary notes that include:</p> <ul style="list-style-type: none"> a) Graphs that are legible and contain: <ul style="list-style-type: none"> i. Title related to behavior measured, ii. X- and Y-axis that are scaled and labeled iii. Labeled gridlines iv. Consecutive and connected data points, v. Legend for data points (when more than one type is used), and vi. Phase lines and labels for changes (i.e., programmatic, environmental, medical, and/or medication changes) 	<p>Monitoring is reflected in the monthly progress note.</p> <ul style="list-style-type: none"> a) Graph must be available and contain all elements. A color graph is acceptable as long as the color copies are available to all members of the support team. b) The progress note should describe these items related to the desired outcome in the objective. c) The progress note should describe these items related to the desired outcome in the objective. May in some cases be "N/A". When "N/A" an explanation is needed. d) This would be documented by a dated, titled meeting sign- in sheet identifying the person, the reason(s) for lack of progress, and the revisions to BSP procedures that are to be implemented

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	<p>b) Visual analysis that includes description of the level, trend, and variability of each behavior along with discussion related to programmatic, environmental, medical, and/or medication changes</p> <p>c) Future (planned) implementation must be described and include any barriers that need to be addressed (e.g., inaccurate implementation, incomplete data collection, etc.), and any changes that need to be made to the procedures based on lack of progress or deteriorating performance, and</p> <p>If fidelity procedures reveal that the BSP is being properly implemented and data properly collected, yet no progress is observed for the problem behavior, replacement behavior, or desired behavior for 3 consecutive months, then the Functional Assessment and its summary must be revisited with input from program implementers to determine the benefits modifying or augmenting BSP procedures or enhancing DSP training</p>	<p>and DSP(s) to be trained for the revision, or justification for no revision.</p> <p>If this is not applicable to the case reviewed then "N/A" with explanation is sufficient. Signature sheets must be in the file.</p> <p>Note: If the fidelity procedures reveal that the BSP is not being properly implemented or data are not being properly collected, then re-training of the DSP(s) is sufficient, and no team meetings or plan modifications are required.</p> <p>Source: Residential Habilitation Standards</p>
RS2-07	When psychotropic medication is given to address problem behavior that poses a significant risk to the person (i.e., self-injury), others (i.e., physical aggression) or the environment (i.e., property destruction) a Behavior Support Plan that addresses the specific behaviors for which the medication is given must be present.	<p>A Behavior Support Plan (BSP) is not required when documentation/data clearly indicates that the person is not exhibiting behavior that poses significant risk. A BSP is not required when evidence supports that the person has reached the lowest effective dosage based on data.</p> <p>Source: 600-05-DD</p>
RS2-08	As needed by the person, but at least quarterly, psychotropic medications and the BSP are reviewed by the prescribing physician, the professional responsible for behavioral interventions, and support team.	Source: 600-05-DD
RS2-09	The specific behaviors/psychiatric symptoms targeted for change by the use of the Psychotropic medication are clearly noted.	Source: 600-05-DD
RS2-10	The Psychotropic Drug Review process provides for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence to the contrary is present.	Source: 600-05-DD
RS2-11	Consent for health care or restrictive interventions is obtained in accordance with 535-07-DD.	Source: 535-07-DD
RS2-12	When prescribed anti-psychotic medication or other medication(s) associated with Tardive Dyskinesia, monitoring is conducted.	<p>Note: If medication associated with Tardive Dyskinesia is prescribed at the time of admission, a baseline T.D. score is obtained within one month.</p> <p>Source: 603-01-DD</p>
RS2-13	Restraints are employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible.	Source documents: 567-04-DD and 600-05-DD.
DS1	<p>Day Services</p> <p>A "DDSN Day Service" includes Employment-Group Services through a Mobile Work Crew or Enclave, Career Preparation Community Service, Day Activity, or Support Center.</p> <p>*With the exception of Employment-Individual (See D2 Indicators)</p>	<p><i>Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.</i></p>

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DS1-01	After acceptance into service but prior to the first day of attendance in a DDSN Day Service, a preliminary plan must be developed that outlines the care and supervision to be provided.	Source: Day Services Standards
DS1-02	On the first day of attendance in a DDSN Day Service, the preliminary plan must be implemented. OBSERVATION: The interventions in the plan are implemented.	Source: Day Services Standards
DS1-03 R	Within thirty (30) calendar days of the first day of attendance in a DDSN Day Service and annually thereafter, an assessment will be completed.	Source: Day Services Standards
DS1-04 R	The assessment identifies the: (1) abilities / strengths, (2) interests / preferences and (3) Needs of the consumer.	Source: Day Services Standards
DS1-05 R	Based on the results of the assessment, within thirty (30) calendar days of the first day of attendance and within 365 days thereafter, a plan is developed with input from the consumer and/or his/her legal guardian.	Source: Day Services Standards
DS1-06 R	The plan must include: a) A description of the interventions to be provided including time limited and measurable goals/objectives when the consumer participates in Employment - Group Services, Career Preparation, Community Services, and/or Day Activity. b) or, a description of the care and assistance to be provided when the consumer participates in Support Center.	Source: Day Services Standards
DS1-07	The plan must include a description of the type and frequency of supervision to be provided.	Source: Day Services Standards and DDSN Directive 510-01-DD
DS1-08	For Support Center Services, the plan must include a description of the kinds of activities in which the consumer is interested or prefers to participate.	Goals and objectives are not required for Support Center Services. Note: This Indicator is N/A for all other Day Services. Source: Day Services Standards
DS1-09 R	The interventions in the plan must support the provision of the DDSN Day Service(s) as defined in the standards.	Source: Day Services Standards
DS1-10	As soon as the plan is developed, it must be implemented.	Source: Day Services Standards
DS1-11 R	Data must be collected as specified in the plan and must be sufficient to support the implementation of the plan for each unit of service reported.	Source: Day Services Standards
DS1-12	At least monthly, the plan is monitored by the Program Director or his/her designee to determine its effectiveness.	Source: Day Services Standards
DS1-13 R	The plan is amended when significant changes to the plan are necessary.	NOTE: Amendments to paper plans must be made using a separate form identified as a plan amendment, indicating the date of the amendment, the name and date of birth, the reason for the amendment, and description of how the plan is being amended. Plans developed in Therap's ISP Programs do not require a paper amendment form but should reflect the reason for the change to the ISP Program. Source: Day Services Standards

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DS1-14	Restraints are employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible.	Source: 567-04-DD and 600-05-DD
DS2 Employment-Individual Placement		<i>Please refer to the Source Documents referenced for specific requirements. Key Indicators are based on DDSN Directives, Service Standards, and Medicaid Policies.</i>
DS2-01 R	A comprehensive vocational service assessment that is appropriate for the authorized service is completed within 30 calendar days of admission/enrollment in the service which is to be provided at a 1:1 staffing ratio.	Source: Employment Services Standards
DS2-02 R	An individual plan of employment is developed within 30 calendar days of admission/enrollment.	Source: Employment Services Standards
DS2-03 R	The record will contain notations that show evidence of monitoring and evaluation of progress.	Source: Employment Services Standards
DS2-04	Individualized, on-the-job instruction and needed and wanted supports are being provided in a nonintrusive method at a 1:1 staffing ratio.	Source: Employment Services Standards
DS2-05	Long-term support plans are identified in the individual plan of employment and contact with the consumer is maintained monthly at a 1:1 staffing ratio.	Source: Employment Services Standards
DS2-06	An exit interview is conducted when a consumer no longer wants the supports, relocates, chooses another provider for supports, enrolls in a nursing home, moves into a correctional facility, or refuses to cooperate with the terms listed in the Statement of Understanding Rights and Responsibilities.	<p>An exit interview must be conducted prior to termination of Employment Services/Individual Placement. A signature must be secured by the individual, if at all possible. If a signature is not secured, a notation as to why the signature was not secured should be made.</p> <p>Source: Employment Services Standards</p>